SECTION 63: IN-HOME AND COMMUNITY SUPPORT SERVICES FOR ELDERLY AND OTHER ADULTS

63.01 DEFINITIONS

(A) In-Home and Community Support Services for Elderly and Other Adults, hereinafter referred to as Home Based Care (HBC), is a state funded program to provide long term care services to assist eligible consumers to avoid or delay inappropriate institutionalization. Provision of these services is based on the availability of funds. State funds furnished through 22 M.R.S.A. §7301-7306 and §7321-7323 may not be used to supplant the resources available from families, neighbors, agencies and/or the consumer or from other Federal, State programs unless specifically provided for elsewhere in this section. State HBC funds shall be used to purchase only those covered services that are essential to assist the consumer to avoid or delay inappropriate institutionalization and which will foster independence, consistent with the consumer's circumstances and the authorized plan of care.

(B) **Activities of daily living (ADLs)**. For purposes of eligibility ADLs shall only include the following as defined in Section 63.02(B): bed mobility, transfer, locomotion, eating, toileting, bathing and dressing.

(C) **Acute/Emergency.** Acute/Emergency means an unscheduled occurrence of an acute episode that requires a change in the physician ordered treatment plan or an unscheduled occurrence where the availability of the consumer's informal support or caregiver is compromised.

(D) **Assessing Services Agency (ASA)** Assessing Services Agency means an organization authorized through a written contract with Bureau of Elder and Adult Services to conduct face-to-face assessments, using the Department's Medical Eligibility Determination (MED) form, and the timeframes and definitions contained therein, to determine medical eligibility for MaineCare and state-funded covered services. Based upon a recipient's assessment outcome scores recorded in the MED form, the Assessing Services Agency is responsible for authorizing a plan of care, which shall specify all services to be provided under this Section, including the number of hours for services, and the provider types. The Assessing Services Agency is the Department's Authorized Agent for medical eligibility determinations and care plan development, and authorization of covered services under this Section.

(E) **Assisted Living Services** means the provision by an assisted housing program, either directly by the provider or indirectly through contracts with persons, entities or agencies, of assisted housing services, assisted housing services with the addition of medication administration or assisted housing services with the addition of medication administration and nursing services.

(F) **Authorized Agent** means an organization authorized by the Department to perform functions, including intake, assessment and case management, under a valid contract or other approved, signed agreement. The Assessing Services Agency and any designated Home Care Coordinating Agency are Authorized Agents under this Section.

(G) **Authorized Plan of Care** means a plan of care which is authorized by the Assessing Services Agency, or the Department, which shall specify all services to be delivered to a recipient under this Section, including the number of hours for all covered services. The plan of care shall be based upon the recipient's assessment outcome scores, and the timeframes contained therein, recorded in the Department's Medical Eligibility Determination (MED) form. The Assessing Services Agency has the authority to determine and authorize the plan of care. All authorized covered services provided under this Section must be listed in the care plan summary on the MED form.

(H) **Behavior threshold**. Problem behavior is wandering with no rational purpose; or verbal abuse; or physical abuse; or socially inappropriate/disruptive behavior. A "threshold" score for problem behavior on the Medical Eligibility Determination (MED) form is equal to a score of 2 or 3 on one of these four criteria and occurs at least 4 days per week.

(I) **Care Plan Summary** is the section of the MED form that documents the Authorized Plan of Care and services provided by other public or private program funding sources or support, and their service category, reason codes, duration, unit code, number of units per month, rate per unit, and total cost per month.

(J) **Cognitive capacity:** The consumer must have the cognitive capacity, as measured on the MED form, to be able to "self direct" the attendant in the self-directed option outlined in Section 63.02(B)(5). This capability will be determined by the Authorized Agent as part of the eligibility determination using the Medical Eligibility Determination (MED) findings. Minimum MED form scores are (a) decision making skills: a score of 0 or 1; (b) making self understood: a score of 0,1, or 2; (c) ability to understand others: a score of 0,1, or 2; (d) self performance in managing finances: a score of 0,1,or 2; and (e) support in managing finances, a score of 0,1,2, or 3. An applicant not meeting the specific scores will be presumed incapable of hiring, firing, training, and supervising the self-directed plan of care.

(K) **Cognitive threshold**. Cognition is the ability to recall what is learned or known and the ability to make decisions regarding tasks of daily life. Cognition is evaluated in terms of:

(1) Memory: short-term and long-term memory;

(2) Memory/recall ability during last seven (7) days, or 24-48 hours if in a hospital; and

(3) Cognitive skills for daily decision making on a scale including: independent; modified independence; moderately impaired; severely impaired;

A "threshold" score for "impaired cognition" on the Medical Eligibility Determination (MED) form is equal to a score of 1 for loss of short term memory and 2 of items A-D or E none for memory/recall ability and a score of 2 or 3 for cognitive skills for decision making.

(L) **Covered Services** are those services for which payment can be made by the Department, under Section 63 of the Bureau of Elder and Adult Services policy manual.

(M) **Cueing** shall mean any spoken instruction or physical guidance which serves as a signal to do an activity. Cueing is typically used when caring for individuals who are cognitively impaired.

(N) **Dependent Allowances.** Dependents and dependent allowances are defined and determined in agreement with the method used in the MaineCare. The allowances are changed periodically and cited in the MaineCare Eligibility Manual, TANF Standard of Need Chart. Dependents are defined as individuals who may be claimed for tax purposes under the Internal Revenue Code and may include a minor or dependent child, dependent parents, or dependent siblings of the consumer or consumer's spouse. A spouse may not be included.

(O) **Disability-related expenses**: Disability-related expenses are out-of-pocket costs incurred by the consumers for their disability, which are not reimbursed by any third-party sources. They include:

(1) Home access modifications: ramps, tub/shower modifications and accessories, power door openers, shower seat/chair, grab bars, door widening, environmental controls;
(2) Communication devices: adaptations to computers, speaker telephone, TTY, Personal Emergency Response systems;
(3) Wheelchair (manual or power) accessories: lap tray, seats and back supports;
(4) Vehicle adaptations: adapted carrier and loading devices, one communication device for emergencies (limited to purchase and installation), adapted equipment for driving;
(5) Hearing Aids, glasses, adapted visual aids;
(6) Assistive animals (purchase only);
(7) Physician ordered medical services and supplies;
(8) Physician ordered prescription and over the counter drugs; and
(9) Medical insurance premiums, co-pays and deductibles.

(P) **Extensive Assistance** means although the individual performed part of the activity over the last 7 days, or 24 to 48 hours if in a hospital setting, help of the following type(s) was required and provided:

(1) Weight-bearing support three or more times, or
(2) Full staff performance during part (but not all) of the last 7 days.

(Q) **Family Provider rates:** The rates for Personal Support Specialist services under the Family Provider Service Option consist of three components: the employer expense component and the PSS family provider wage component and the payroll agent (FI) cost

(1) **PSS rate**-portion of the PSS rate that is designated as the PSS's gross hourly wage for authorized care provided by the family provider
(2) **Family Provider expense component-**the portion of the family provider rate designated as reimbursement to consumers for their mandated employer's share of social security, federal and state unemployment taxes, Medicare, and worker's compensation insurance premiums
(3) **Administrative rate-**Fee paid by the family provider to the FI for payroll services

(R) **Family Provider Service Option** a service provision option that allows an adult, twenty-one years or older, to register as a Personal Care Agency solely for the purpose of managing his or her own services or solely for managing the services of no more then two of his/her family members. For purposes of this definition only, family members include individuals related by blood, marriage or adoption as well as two unmarried adults who are domiciled together under a long- term arrangement that evidences a commitment to remain responsible indefinitely for each other's welfare.

(S) **Fiscal Intermediary (FI)** is an organization that provides administrative and payroll services on behalf of family providers who employ and manage their own support workers. FI services include, but are not limited to, preparing payroll withholding taxes, making payments to suppliers of goods and services and ensuring compliance with state and federal tax, labor and Home Based Care program requirements.

(T) **Health Maintenance Activities** are activities designed to assist the consumer with Activities of Daily Living and Instrumental Activities of Daily Living, and additional activities specified in this definition. These activities are performed by a designated caregiver for a competent self-directing individual that would otherwise perform the activities, if he or she were physically able to do so and enable the individual to live in his or her home and community. These additional activities include, but are not limited to, catheterization, ostomy care, preparation of food and tube feedings, bowel treatments, administration of medications, care of skin with damaged integrity, occupational and physical therapy activities such as assistance with prescribed exercise regimes.

(U) **Home Care Coordinating Agency**. The Home Care Coordinating Agency means an organization authorized, through a written contract with Bureau of Elder and Adult Services to conduct a range of activities which includes the following:

coordinate and implement the services in the consumer's plan of care authorized by the Assessing Services Agency; ensure that authorized services in the care plan summary are delivered according to the service authorizations; reduce, deny, or terminate services under this section; serve as a resource to consumers and their families to identify available service delivery options and service providers; answer questions; and assist with resolving problems. The Home Care Coordinating Agency is also responsible for administrative functions, including: maintaining consumer records; processing claims; overseeing and assuring compliance with policy requirements by any and all sub-contractors; final determination of the consumer copayment on receipt of the required information and collection of consumer co-payments: and conducting required utilization review activities.

(V) **Income** includes:

(1) Wages from work, including payroll deductions, excluding state and Federal taxes and employer mandated or court ordered withholdings;

(2) Benefits from Social Security, Supplemental Security Insurance, pensions, insurance, independent retirement plans, annuities, and Aid and Attendance;

(3) Adjusted gross income from property and/or business, based on the consumer's most recent Federal income tax; and

(4) Interest and dividends.

Not included are benefits from: the Home Energy Assistance Program, Food Stamps, General Assistance, Property Tax and Rent Refund, emergency assistance programs, or their successors.

(W) **Instrumental Activities of Daily Living (IADLs).** For purposes of the eligibility criteria under this section of policy, IADLs are defined in section 63.02 (B) and are limited to the following: main meal preparation: preparation or receipt of the main meal; routine housework; grocery shopping and storage of purchased groceries; and laundry either within the residence or at an outside laundry facility.

(X) **Limited Assistance** means the individual was highly involved in the activity over the past seven days, or 24 to 48 hours if in a hospital setting, but received and required

- guided maneuvering of limbs or other non-weight bearing physical assistance three or more times or
- guided maneuvering of limbs or other non-weight bearing physical assistance three or more times plus weight-bearing support provided only one or two times

(Y) **Liquid asset** is something of value available to the consumer that can be converted to cash in three months or less and includes:

(1) Bank accounts;

(2) Certificates of deposit;
(3) Money market and mutual funds;
(4) Life insurance policies;
(5) Stocks and bonds;
(6) Lump sum payments and inheritances; and
(7) Funds from a home equity conversion mortgage that are in the consumer's possession whether they are cash or have been converted to another form.

Funds which are available to the consumer but carry a penalty for early withdrawal will be counted minus the penalty. Exempt from this category are mortuary trusts and lump sum payments received from insurance settlements or annuities or other such assets named specifically to provide income as a replacement for earned income. The income from these payments will be counted as income.

(Z) **Long term care needs** are those needs determined as a result of completion of the Medical Eligibility Determination form, resulting from an individual's inability to manage ADLs and IADLs, as a result of physical, emotional, or developmental problems.

(AA) A medical condition is unstable when it is fluctuating in an irregular way and/or is deteriorating and affects the client's ability to function independently. The fluctuations are to such a degree that medical treatment and professional nursing observation, assessment and management at least once every 8 hours is required. An unstable medical condition requires increased physician involvement and should result in communication with the physician for adjustments in treatment and medication. Evidence of fluctuating vital signs, lab values, and physical symptoms and plan of care adjustments must be documented in the medical record. Not included in this definition is the loss of function resulting from a temporary disability from which full recovery is expected.

(BB) **Medical Eligibility Determination (MED) Form** shall mean the form approved by the Department for medical eligibility determinations and service authorization for the plan of care based upon the assessment outcome scores. The definitions, scoring mechanisms and time-frames relating to this form as defined in Section 63 provide the basis for services and the care plan authorized by the Assessing Services Agency. The care plan summary contained in the MED form documents the authorized care plan to be implemented by the Home Care Coordinating Agency in the service order. The care plan summary also identifies other services the recipient is receiving, in addition to the authorized services provided under this Section.

(CC) **Multi-disciplinary team (MDT). The MDT** includes the consumer, the designated home care coordinating agency staff person as appropriate, the RN

assessor, or a health professional and may also include other people who provide or have an interest in the consumer's services.

(DD) One-person Physical Assist requires one person over the last seven (7) days or 24-48 hours if in a hospital setting, to provide either weight-bearing or non-weight bearing assistance for an individual who cannot perform the activity independently. This does not include cueing.

(EE) Personal Support Services (formerly known as Personal care assistance) are those covered ADL and IADL services provided by a home health aide, certified nursing assistant or personal support specialist, which are required by an adult with long-term care needs to achieve greater physical independence, in accordance with the authorized plan of care.

(FF) Personal Support Specialist (PSS) is a person who provides personal support services and has completed a Department approved training course of at least 50 hours, unless otherwise exempt under Section 63, which includes, but is not limited to, instruction in basic personal care procedures, such as those listed in Section 63.02(B)(1)(b), first aid, handling of emergencies and review of the mandatory reporting requirement under the Adult Protective Services Act. PSS are unlicensed assistive personnel as defined in Title 22 MRSA § 1717(1)(D).

(GG) Provider means any entity , agency, facility or individual who offers or plans to offer any in-home or community support services.

(HH) A quality assurance review committee (QARC) is a group sponsored by the Bureau of Elder and Adult Services, whose responsibility it is to review randomly selected consumer cases to assess the appropriateness and quality of authorized care plans and services delivered and to make recommendations for improving quality of care, outcomes for the consumer, and policy changes.

(II) Residential care facility- means a house or other place that, for consideration, is maintained wholly or partly for the purpose of providing residents with assisted living services. Residential care facilities provide housing and services to residents in private or semi-private bedrooms in buildings with common living areas and dining areas. “Residential Care facility” does not include a licensed nursing home or a supported living arrangement certified by DHHS (formerly DBDS) for behavioral and developmental services.

(JJ) Service order means the document used by the Home Care Coordinating Agency to engage and order the subcontractor or independent contractor to complete the tasks, authorized by the Assessing Services Agency on the care plan summary of the MED form. The hours on the service order shall not exceed the hours authorized on the MED form care plan summary and must include only the covered services from Section 63.04.

(KK) Significant change. A significant change is defined as a major change in the consumer's status that is not self limiting, impacts on more than one area of their functional or health status, and requires multi-disciplinary review or revision of the plan of care. A significant change assessment is appropriate if there is a consistent pattern of changes, with either two or more areas of improvement, or two or more areas of decline, that requires a review of the care plan and potential for a level of care change.

(LL) Signature. Effective with the implementation of the computerization of the Medical Eligibility Determination (MED) form, signature of the RN assessor or the HCCA staff will equate with "login" onto the appropriate electronic system.

(MM) Skills training-consumer instruction- Instructional services provided by the HCCA to assist family providers under the Family Provider Option who have attained prior authorization for PSS services, in developing the skills and activities related to the fiscal intermediary.

(NN) Unlicensed Assistive Personnel means individuals, including personal support specialists and homemakers, who, as defined in Title 22 MRSA § 1717, are employed to provide hands-on assistance with daily living to individuals in homes, assisted living centers, residential care facilities, hospitals and other health care settings. Unlicensed assistive personnel does not include certified nursing assistants employed in their capacity as certified nursing assistants.

(OO) Total Dependence means full staff person/caregiver performance of the activity during the entire last seven (7) day period across all shifts, or during each eight hour period in twenty four (24) hours.

63.02 ELIGIBILITY

(A) General and Specific Requirements. To be eligible for services a consumer must:

(1) Be at least 18;
(2) Live in Maine;
(3) For an individual, have liquid assets of no more than $50,000, or for couples have assets of no more than $75,000.
(4) Lack sufficient personal and/or financial resources for in-home services;
(5) Be ineligible for the MaineCare Private Duty Nursing/Personal Care Services except as otherwise provided in this Section, MaineCare Home and Community Based Waiver, MaineCare Adult Day Health, MaineCare Consumer-Directed Attendant Services programs.;
(6) Not be participating in Section 61: Adult Day Services, Section 62: Independent Housing with Services, Section 68: Respite Care for People with Alzheimer's Disease or Related Disorders, Section 69: Bureau of

Elder and Adult Services Homemaker Services or Consumer-Directed Home Based Care program enacted by 26 MRSA 1412-G;

(7) Not be residing in an Assisted Housing-Program including a Residential Care facility, or a supported living arrangement certified by DHHS (formerly DBDS) for behavioral and developmental services unless the consumer meets the eligibility criteria for Level IV services under this section;

(8) Not be residing in a hospital or nursing facility;

(9) Consumer or legal representative agrees to pay the monthly calculated consumer payment; and

(10) If the assessment for continued eligibility indicates medical eligibility for a MaineCare program and potential financial eligibility for MaineCare, consumers will be given written notice, that the consumer has up to thirty (30) days to file a MaineCare application. If HBC services are currently being received, services shall be discontinued if a Bureau of Family Independence notice is not received within thirty (30) days of the assessment date indicating that a financial application has been filed. Services shall also be discontinued if, after filing the application within thirty (30) days the application requirements have not been completed in the time required by MaineCare policy. No further notice of termination is required in order for the termination to be effective as soon as MaineCare eligibility is established. Service under this section will not be terminated if MaineCare eligibility is denied.

(B) Medical and Functional Eligibility Requirements

Applicants for services under this section must meet the eligibility requirements as set forth in this Section 63.02(B) and documented on the Medical Eligibility Determination (MED) form. Medical eligibility will be determined using the MED form as defined in Section 63.01. A person meets the medical eligibility requirements for Home Based Care if he or she requires a combination of items from Activities of Daily Living 63.02(B)(1)(b), Instrumental Activities of Daily Living Section 63.02(B)(1)(c) and Nursing Services 63.02(B)(1)(d) The levels of care define which combined items are required for each level of care. 63.02 (1) OR (2) OR (3) OR (4) below. The clinical judgment of the Department's Assessing Services Agency shall be the basis of the scores entered on the Medical Eligibility Determination (MED) form.

(1) **Level I** A person meets the medical eligibility requirements for Level I of Home Based Care if he or she requires the combination of criteria of Activities of Daily Living, Instrumental Activities of Daily Living and Nursing Services, as described below:

(a) Eligibility items

(i) Requires cueing 7 days per week for eating, toilet use, bathing, and dressing as defined in Section 63.01(L); or

(ii) Requires limited assistance plus a one person physical assist with at least two (2) ADLs from the following: bed

mobility, transfer, locomotion, eating, toilet use, dressing, and bathing and assistance/done with help plus physical assistance with at least one (1) IADL; or

(iii) Requires limited assistance plus a one person physical assist with at least one (1) ADL from the following: bed mobility, transfer, locomotion, eating, toilet use, dressing, and bathing and assistance/done with help plus physical assistance with at least two (2) IADLs from the following: main meal preparation, routine housework, grocery shopping, and laundry; or

(iv) Requires limited assistance plus a one person physical assist with at least three (3) ADLs from the following: bed mobility, transfer, locomotion, eating, toilet use, dressing, and bathing or

(v) Requires one of the nursing services items i – xi below, at least once per week, that are or otherwise would be performed by or under the supervision of a registered professional nurse, as described in Section 63.02(B)(1)(d) below and limited assistance plus a one person physical assist with at least two (2) ADLs from the following: bed mobility, transfer, locomotion, eating, toilet use, dressing, and bathing: or

(vi) Requires two (2) of the nursing services items i – xi below, at least once per week, that are or otherwise would be performed by or under the supervision of a registered professional nurse, as described in Section 63.02 (B)(1)(d) below and limited assistance plus a one person physical assist with at least one (1) ADL from the following: bed mobility, transfer, locomotion, eating, toilet use, dressing, and bathing or

(vii) Requires one of the nursing services items i – xi below, at least once per week, that are or otherwise would be performed by or under the supervision of a registered professional nurse, as described in Section 63.02 (B)(1)(d) below and limited assistance plus a one person physical assist with at least one (1) ADL from the following: bed mobility, transfer, locomotion, eating, toilet use, dressing, and bathing and assistance/done with help plus physical assistance with at least one (1) IADL from the following: main meal preparation, routine housework, grocery shopping, and laundry:

(b) Activities of Daily Living:

(i) Bed Mobility: How person moves to and from lying position, turns side to side, and positions body while in bed;

(ii) Transfer: How person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet);

(iii) Locomotion: How person moves between locations, in room and other areas. If in wheelchair, self-sufficiency once in chair;

(iv) Eating: How person eats and drinks (regardless of skill);

(v) Toilet Use: How person uses the toilet room (or commode, bedpan, urinal): transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes;

(vi) Bathing: How person takes full-body bath/shower, sponge bath and transfers in/out of tub/shower (exclude washing of back and hair); and

(vii) Dressing: How person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis.

(c) Instrumental activities of daily living.

(i) "Instrumental activities of daily living (IADLs)" are regularly necessary home management activities listed below:

(ii) Daily instrumental activities of daily living (within the last 7 days):

(aa) main meal preparation: preparation or receipt of main meal;

(iii) Other instrumental activities of daily living (within the last 14 days):

(aa) routine housework: includes, but is not limited to vacuuming, cleaning of floors, trash removal, cleaning bathrooms and appliances;

(bb) grocery shopping: shopping for groceries and storage of purchased food or prepared meals;

(cc) laundry: doing laundry in home or out of home at a laundry facility;

(d) Nursing Services

(i) intraarterial, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding for treatment of unstable conditions requiring medical or nursing intervention other than daily insulin injections for an individual whose diabetes is under control;

(ii) nasogastric tube, gastrostomy, or jejunostomy feeding, for a new/recent (within past 30 days) or unstable condition;

(iii) nasopharyngeal suctioning or tracheostomy care; however, care of a tracheostomy tube must be for a recent (within past 30 days) or unstable condition;

(iv) treatment and/or application of dressings when the physician has prescribed irrigation, the application of

prescribed medication, or sterile dressings of stage III and IV decubitus ulcers, other widespread skin disorders (except psoriasis and eczema), or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, 2nd or 3rd degree burns, open surgical sites, fistulas, tube sites, and tumor erosions);

(v) administration of oxygen on a regular and continuing basis when the recipient's medical condition warrants professional nursing observations, for a new or recent (within past 30 days) condition;

(vi) professional nursing assessment, observation and management of an unstable medical condition (observation must, however, be needed at least once every eight hours throughout the 24 hours);

(vii) insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition may justify a need for skilled nursing care. In such instances, the need for a catheter must be documented and justified in the recipient's medical record;

(viii) services to manage a comatose condition;

(ix) care to manage conditions requiring a ventilator/respirator;

(x) direct assistance from others is required for the safe management of an uncontrolled seizure disorder, (i.e.: grandmal);

(xi) physical, speech/language, occupational, or respiratory therapy provided as part of a planned program that is designed, established, and directed by a qualified licensed therapist. The findings of an initial evaluation and periodic reassessments must be documented in the recipient's medical record. Skilled therapeutic services must be ordered by a physician and be designed to achieve specific goals within a given time frame;

(2) Level II. A person meets the medical eligibility requirements for Level II of Home Based Care if he or she requires any of the nursing services, items i to xvi below, at least once per month, that are or otherwise would be performed by or under the supervision of a registered professional nurse, as described below in Section 63.02(B)(2)(a)

(a) Nursing Services

(i) intraarterial, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding for treatment of unstable conditions requiring medical or nursing intervention other than daily insulin injections for an individual whose diabetes is under control;

(ii) nasogastric tube, gastrostomy, or jejunostomy feeding, for a new/recent (within past 30 days) or unstable condition;

(iii) nasopharyngeal suctioning or tracheostomy care; however, care of a tracheostomy tube must be for a recent (within past 30 days) or unstable condition;

(iv) treatment and/or application of dressings when the physician has prescribed irrigation, the application of prescribed medication, or sterile dressings of stage III and IV decubitus ulcers, other widespread skin disorders (except psoriasis and eczema), or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, 2nd or 3rd degree burns, open surgical sites, fistulas, tube sites, and tumor erosions);

(v) administration of oxygen on a regular and continuing basis when the recipient's medical condition warrants professional nursing observations, for a new or recent (within past 30 days) condition;

(vi) professional nursing assessment, observation and management of an unstable medical condition (observation must, however, be needed at least once every eight hours throughout the 24 hours);

(vii) insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition may justify a need for skilled nursing care. In such instances, the need for a catheter must be documented and justified in the recipient's medical record;

(viii) services to manage a comatose condition;

(ix) care to manage conditions requiring a ventilator/respirator;

(x) direct assistance from others is required for the safe management of an uncontrolled seizure disorder, (i.e.: grandmal);

(xi) physical, speech/language, occupational, or respiratory therapy provided as part of a planned program that is designed, established, and directed by a qualified licensed therapist. The findings of an initial evaluation and periodic reassessments must be documented in the recipient's medical record. Skilled therapeutic services must be ordered by a physician and be designed to achieve specific goals within a given time frame; or

(xii) Professional nursing assessment, observation and management of a medical condition;

(xiii) administration of treatments (excluding nebulizers), procedures, or dressing changes which involve prescription medications, for post-operative or chronic conditions according to physician orders, that require nursing care and monitoring;

(xiv) professional nursing for physician ordered radiation

therapy, chemotherapy, or dialysis;

(xv) professional nursing assessment, observation and management for impaired memory, and impaired recall ability, and impaired cognitive ability;

(xvi) professional nursing assessment, observation, and management for problems including wandering, or physical abuse, or verbal abuse or socially inappropriate behavior;

(a) In addition to above, one of the following:

(i) requires daily (7 days per week) "Cueing" (defined in Section 63.01(L)) for all of the following criteria: 63.02(B)(2)(c)(eating, toilet use, bathing, and dressing),

OR

(ii) At least "limited assistance" (defined in 63.01(U)) and a "one person physical assist" (defined in 63.01(AA) is needed with at least two of the following: bed mobility, transfer, locomotion, eating, toilet use, dressing, and bathing as defined below in Section 63.02(B)(2)(c):

(b) Activities of Daily Living:

(i) Bed Mobility: How person moves to and from lying position, turns side to side, and positions body while in bed;

(ii) Transfer: How person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet);

(iii) Locomotion: How person moves between locations, in room and other areas. If in wheelchair, self-sufficiency once in chair;

(iv) Eating: How person eats and drinks (regardless of skill);

(v) Toilet Use: How person uses the toilet room (or commode, bedpan, urinal): transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes;

(vi) Bathing: How person takes full-body bath/shower, sponge bath and transfers in/out of tub/shower (exclude washing of back and hair); and

(vii) Dressing: How person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis.

(c) Instrumental activities of daily living.

"Instrumental activities of daily living (IADLs)" are regularly necessary home management activities listed below:

(i) Daily instrumental activities of daily living (within the last 7 days)

(aa) main meal preparation: preparation or receipt of main meal;

(ii) Other instrumental activities of daily living (within the last

14 days):

(bb) routine housework: includes, but is not limited to vacuuming, cleaning of floors, trash removal, cleaning bathrooms and appliances;

(cc) grocery shopping: shopping for groceries and storage of purchased food or prepared meals;

(dd) laundry: doing laundry in home or out of home at a laundry facility;

(3) Level III A person meets the medical eligibility requirements for Level III of Home Based Care if he or she requires at least "limited assistance and a "one person physical assist" in two of the following five ADLs: and assistance/done with help plus physical assistance with at least three IADLs from the following:

(a) Activities of Daily Living:

(i) Bed Mobility: How person moves to and from lying position, turns side to side, and positions body while in bed;

(ii) Transfer: How person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet);

(iii) Locomotion: How person moves between locations, in room and other areas. If in wheelchair, self-sufficiency once in chair;

(iv) Eating: How person eats and drinks (regardless of skill);

(v) Toilet Use: How person uses the toilet room (or commode, bedpan, urinal): transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes;

(b) Instrumental activities of daily living.

"Instrumental activities of daily living (IADLs)" are regularly necessary home management activities listed below:

(i) Daily instrumental activities of daily living (within the last 7 days)

(aa) main meal preparation: preparation or receipt of main meal;

(ii) Other instrumental activities of daily living (within the last 14 days):

(aa) routine housework: includes, but is not limited to vacuuming, cleaning of floors, trash removal, cleaning bathrooms and appliances;

(bb) grocery shopping: shopping for groceries and storage of purchased food or prepared meals;

(cc) laundry: doing laundry in home or out of home at a laundry facility;

(4) Level IV A person meets the medical eligibility requirements for this level IV of Home Based Care if he or she meets the medical eligibility

requirements for nursing facility level of care set forth in Chapter 2, Section 67.02-3 Nursing Facility Services of the MaineCare Benefits Manual.

63.03 DURATION OF SERVICES

Each Home Based Care consumer may receive as many covered services as are required within the limitations and exceptions as described below. Home Based Care coverage of services under this Section requires prior authorization from the Department or its Assessing Services Agency. Beginning and end dates of a consumer's medical eligibility determination period correspond to the beginning and end dates for Home Based Care coverage of the plan of care authorized by the Assessing Services Agency or the Department.

(A) Exception to the Limit: For consumers accessing Adult Day Services reimbursed by HBC funds, the caps may be exceeded by an amount determined by the Department.

(B) Consumers classified for Level I level of care (see Section 63.02(B)(1)), the total monthly cost of services may not exceed the lesser of the monthly plan of care authorized by the Assessing Services Agency or the "Level I" cap, established by the Department.

(C) Consumers classified for Level II level of care (see Section 63.02(B)(2)), the total monthly cost of services may not exceed the lesser of the monthly plan of care authorized by the Assessing Services Agency or the "Level II" cap established by the Department.

(D) Consumers classified for Level III level of care (see Section 63.02(B)(3)), the total monthly cost of services may not exceed the lesser of the monthly plan of care authorized by the Assessing Services Agency or the "Level III" cap established by the Department.

(E) Consumers classified for Level IV level of care (see Section 63.02(B)(4)), the total monthly cost of services may not exceed the lesser of the monthly plan of care authorized by the Assessing Services Agency or 67%-of the average cost of nursing facility level of care established by the Department.

(F) Suspension. Services may be suspended for up to thirty (30) days for reasons stated in Section 63.03 (G). If the circumstances requiring suspension extend beyond thirty (30) days, the consumer's eligibility in the program will be terminated.

(G) Services under this Section shall be suspended, reduced, denied or terminated by the Department, the Assessing Services Agency, or the Home Care Coordinating Agency, as appropriate, for one or more of the following reasons:

(1) The consumer does not meet eligibility requirements;

(2) The consumer declines services;

(3) The consumer is eligible to receive long-term care services under MaineCare including any MaineCare Special Benefits, except as otherwise provided in this section for MaineCare Private Duty Nursing/Personal Care Services;

(4) The consumer is eligible and chooses to receive services under the

Consumer Directed Home Based Care Program enacted by 26 MRSA Section 1412-G;

(5) The consumer appears to be eligible for long term care services under MaineCare pursuant to the procedure set forth in Section 63.02(A)(10);

(6) Based on the consumer's most recent MED assessment, the plan of care is reduced to match the consumer's needs as identified in the reassessment and subject to the limitations of the program ;

(7) The health or safety of individuals providing services is endangered; or

(8) Services have been suspended for more than thirty (30) days; or

(9) Consumer refuses personal care or nursing services; or

(10) Consumer has failed to make his/her calculated monthly co-payment within thirty (30) days of receipt of the co-pay bill ; or

(11) When the consumer or designated representative gives fraudulent information to Department of Human Services, the Assessing Services Agency or Home Care Coordinating Agency; or

(12) The consumer is eligible to receive home health services for some or all of the services authorized under this section from Medicare or another third party payer; or

(13) The availability of informal or formal supports, including public and private sources, duplicate the services provided under this section; or

(14) There are insufficient funds to continue to pay for services for all current consumers which results in a change affecting some or all consumers.

Notice of intent to reduce, deny, or terminate services under this section will be done in accordance with Section 40.01 of this policy manual.

63.04 COVERED SERVICES

Covered services are available for consumers meeting the eligibility requirements set forth in Section 63.02. All covered services require prior authorization by the Department, or its Assessing Services Agency, consistent with these rules, and are subject to the limits in Section 63.03. The Authorized Plan of Care shall be based upon the consumer's assessment outcome scores recorded on the Department's Medical Eligibility Determination (MED) form, according to it's definitions, and the timeframes therein and the Task Time Allowances defined in the appendix to this section.

Services provided must be required for meeting the identified needs of the consumer, based upon the outcome scores on the MED form, and as authorized in the plan of care. Coverage will be denied if the services provided are not consistent with the consumer's authorized plan of care. The Department may also recoup payment from the Home Care Coordinating Agency for inappropriate services provision, as determined through post payment review. The Assessing Services Agency has the authority to determine the plan of care, which shall specify all services to be provided, including the number of hours for each covered service.

The Assessing Services Agency will use Task Time Allowances set forth in the appendix to this section to determine the time needed to complete authorized ADL tasks for the plan of care not to exceed the program limits specified elsewhere in this section.

Covered Services are:

(A) **Care Coordination,** or case management, is a system for identifying, implementing, locating, coordinating, reviewing, and monitoring consumer's need for services as authorized by the Assessing Services Agency during the eligibility determination process.

Care Coordination tasks performed by a Home Care Coordinating Agency which are required for overall program administration, management, distribution of funds and reporting include, but are not limited to:

(1) Ensuring the implementation, monitoring and modification of the consumer plan of care authorized by the Assessing Services Agency;
(2) Advocating on behalf of the consumer for access to appropriate community resources;
(3) Implementing the Assessing Services Agency authorized care plan and coordinating of service providers who are responsible for delivery of services pursuant to the consumer's authorized plan of care and identified needs;
(4) Maintaining contacts, on behalf of the consumer, with family members, designated representative, guardian, providers of services or supports and the Assessing Services Agency to ensure the continuity of care and coordination of services;
(5) Monitoring the services and support; and evaluating the effectiveness of the plan with the consumer or the designated representative, guardian and providers of services or support;
(6) Calculating the consumer's co-payment based on the estimated copayment determined by the Assessing Services Agency and receipt and review of the documented dependent allowances and disability related expenses. Consumers receiving services under this section may be selected for verification of income and assets;
(7) Notifying the Assessing Services Agency of the due date of the annual financial reassessment.
(8) Coordinating and requesting of required and unscheduled reassessments including the provision of an up to date status report of the consumer and their situation.
(9) Preparing the consumer for the reassessment process.
(10) Beginning discharge planning on the first day of services. A discharge plan will enable the consumer to transition to other services, as appropriate;
(11) In the event a consumer experiences an unexpected need, the Home Care Coordinating Agency has the authority to adjust the frequency of services

under the authorized care plan, in order to meet the needs, as long as the total authorized care plan hours for the eligibility period are not exceeded

(12) In the event a consumer experiences an emergency or acute episode as defined in Section 63.01(C), the Home Care Coordinating Agency has the authority to adjust the authorized plan of care up to 15% of the monthly authorized amount not to exceed the applicable cap. Services resulting from an acute or emergency incident may not continue beyond fourteen (14) days and the Home Care Coordinating Agency must request a reassessment on the date the increase is implemented;

(13) Issuing a "notice of intent to reduce, deny or terminate HBC services" as defined and applicable in Section 63.03.

(14) Other administrative tasks include, but are not limited to:

(a) Processing assessment packets;
(b) Maintaining consumer records;
(c) Tracking and reporting services;
(d) Preparing the Home Care Coordinating Agency budget and processing of claims to the Department;
(e) Contracting with service providers including fiscal intermediaries and requiring compliance by any and all sub-contractors with policy requirements; and conducting required utilization review activities.
(f) Reimbursing subcontracted home care providers; and
(g) Preparing information as required by the Department.

(B) Care Monitoring. Care monitoring are those services provided by a licensed social services or health professional (contracted with or employed by a Home Care Coordinating Agency), to assist a Home Care Coordinating Agency to identify the medical, social, educational, and other needs of an eligible consumer, and facilitate access to needed services. Care monitoring may be provided only to eligible consumers who are receiving or awaiting other authorized HBC services. Care monitoring is provided according to the plan of care authorized by the Assessing Services Agency and implemented by a Home Care Coordinating Agency. The care monitor will complete the following activities and report findings to the Home Care Coordinating Agency based on the task specific authorization:

(1) monitor services delivered;
(2) evaluate the effectiveness of the implementation of the authorized plan of care;
(3) advocate on behalf of the consumer;
(4) counsel the consumer or responsible party about the plan of care authorized by the Assessing Services Agency ;
(5) evaluate the consumer's health status and services needs;
(6) identify gaps in service or care needs;
(7) document and submit to the Home Care Coordinating Agency progress notes that include the outcome of the face-to-face care monitoring; and
(8) make recommendations for any authorized care plan modifications or need for referrals to community resources.

(C) **Diagnostic Services**. Diagnostic services necessary and not covered by a third party payor, to enhance the authorized plan of care, including independent living evaluation. Exclude venipuncture services.

(D) **Homemaking Services**. Homemaking services means services to assist a consumer with his or her general housework, meal preparation, grocery shopping, laundry, and incidental personal hygiene and dressing. If the consumer is receiving care at Level I, IADL tasks may constitute up to, but shall not exceed, 2 hours per week of authorized services.

(E) **Personal Support Services (PSS)**. Personal support_services to aid consumers with ADLs and IADLs.

(1) Personal support ADL services include bed mobility, transfer, locomotion, eating, toilet use, bathing and personal hygiene, dressing, and health maintenance activities. When authorizing a plan of care that includes personal support services the Assessing Services Agency will use the task time allowances specified in the appendix attached to this section not to exceed limits specified elsewhere in this Section. ADL services may be provided in the consumer's residence or at an adult day services program.

(2) Personal Support IADL services include meal preparation, grocery shopping, routine housework and laundry, which are directly related to the consumer's plan of care.

(a) These tasks must be performed in conjunction with direct care to the consumer.

(a) These IADL tasks would otherwise be normally performed by the consumer if he or she were physically or cognitively able to do so, and it must be established by the Assessing Services Agency that there is no family member or other person available and willing to assist with these tasks.

(c) If the consumer is receiving care at Level I, IADL tasks may constitute up to, but shall not exceed, 2 hours per week ~~month~~ of authorized personal care services. I

(d) If the consumer is receiving care at Level II, IADL tasks may constitute up to, but shall not exceed, 3 hours per week of authorized personal support services,

(e) If the consumer is receiving care at Level III, IADL tasks may constitute up to, but shall not exceed, 4 hours per week of authorized personal support services.

(f) If the consumer is receiving care at Level IV, IADL tasks may constitute up to, but shall not exceed, 6 hours per week of authorized personal support services, The services authorized may not exceed 67% of average cost of nursing facility care established by the Department.

(3) All personal support services may be used for ADLs if necessary.

(4) No individual providing this service may be reimbursed for more than 40 hours of care per week for an individual consumer.

(5) When authorizing a consumer's plan of care, personal support services for ADLs must be authorized in accordance with the Task Time Allowances not to exceed programs caps or limits specified elsewhere in this section (see appendix to this section). If these times are not sufficient when considered in the light of a consumer's-unique-circumstances as identified by the authorized agent, the authorized agent may make an appropriate adjustment as long as the authorized hours do not exceed limits established for consumer's level of care Task time allowances will consider the possibility for concurrent performances of activities and tasks listed. Services listed in the Task Time Allowances that are not covered services under this section may not be authorized.

(6) The "one Hour" PSS visit is a one –hour visit to deliver personal care services and health maintenance activities to a member, no more then once per day. This service may be authorized up to seven days per week. If a person requires more then one hour of personal care service on a given day, then the PSS services must be billed using the half-hour units.

(F) **Handyman/Chore Service**. Chore services to assist a consumer with occasional heavy-duty cleaning, raising and lowering of combination screen/storm windows, repairs and similar minor tasks to eliminate safety hazards in the environment.

(G) **Home Health Services**. Home health services to assist a consumer with health and medical and ADL needs as identified on the MED form and authorized by the Assessing Services Agency. These include nursing; home health aide and certified nursing assistant services; physical, occupational, and speech therapy; and medical social services, when no other method of third party payment is available. Home Health services may only be purchased from licensed agencies and shall be reimbursed at an hourly rate. When authorizing personal care services provided by a HHA or CNA, the Assessing Services Agency must use the task time allowances set forth in the appendix attached to this section to authorize the time covered to complete authorized ADL and IADL tasks for the plan of care not to exceed the program caps or limits specified elsewhere in this section.

(H) **Respite**. Services provided to individuals, furnished on a short-term basis because of the absence of or need for relief of the caregiver. This service may be provided at home, in a licensed Adult Day Program, or in an institutional setting. An institution is:

(1) An assisted housing program licensed in accordance with 22 M.R.S.A. §7851(2) excluding independent housing with services programs;
(2) A nursing facility or unit, licensed in accordance with 22 M.R.S.A. §1811-1824;
(3) An acute care or rehabilitation facility, licensed in accordance with 22 M.R.S.A. §1811-1824; or
(4) A facility for the treatment or management of people who have mental retardation or mental illness.

The annual cost of respite services may not exceed an annual cap as established by the Bureau of Elder and Adult Services and is included in the individual's

annual care plan cost limit. A consumer receiving MaineCare Private Duty Nursing/Personal Care Services may receive respite services to the extent that budgeted resources permit and to the extent that there is no waiting list under Section 63.

(I) **Transportation**. Personal Support Specialists, Certified nursing assistants, home health aides and homemakers may escort or transport a consumer only to carry out the plan of care. Any individual providing transportation must hold a valid State of Maine driver's license for the type of vehicle being operated. All providers of transportation services shall maintain adequate liability insurance coverage for the type of vehicle being operated. Escort services may be provided only when a consumer is unable to be transported alone, there are no other resources (family or friends) available for assistance, and the transportation agency can document that the agency is unable to meet the request for service. Reimbursement shall only be made for mileage in excess of ten (10) miles per single trip on a one-way trip for transportation provided by personal care assistants, homemakers, or other home health providers in the course of delivering a covered service under this section.

(J) **Adult Day Services**. Adult day services furnished by providers who are licensed and certified by the Department of Human Services.

(K) **Mental Health**. Mental health services provided by licensed mental health practitioners.

(L) **Home Modification**. Home modifications necessary to promote independent living and carry out the plan of care up to a life time cost of $3,000, and when there is no alternative source of funding.

(M) **Personal Emergency Response System (PERS).** A Personal Emergency Response System is an electronic device which enables certain high-risk individuals to secure help in the event of an emergency. PERS services may be provided to those individuals who live alone, or who are alone for significant parts of the day, who are capable of using the system, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

63.05 NON COVERED SERVICES

The following services are not reimbursable under this Section:

(A) Rent and Board

(B) Services for which the cost exceeds the limits described in Section 63.03 and 63.04, except as described in 63.03(A);

(C) Personal Support Specialist services (defined in 63.01(BB) delivered in a licensed or unlicensed Assisted Housing Program, including a Residential Care facility, or a supported living arrangement certified by DHHS (formerly DBDS) for behavioral and developmental services unless the consumer meets the eligibility criteria for Level IV of services. It is the responsibility of the -Provider, as defined in Section 63.01 (FF), to deliver personal care services. For individuals qualifying for Level IV, the combined cost of HBC services and Assisted Housing

services may not exceed the lesser of the monthly plan of care authorized by the Assessing Services Agency or 67% of the average cost of nursing facility level of care established by the Department. For these Level IV consumers HBC may not be used for personal support specialist services, ADL or IADL tasks, or in home respite.

(D) Services provided by anyone prohibited from employment under the following:

(1) a personal support specialist or homemaker who is prohibited from employment under Title 22 MRSA 1717(3), §2149-A, §7851, or §8606; or

(2) a certified nursing assistant who is prohibited from employment under Title 22 MRSA 1812(G).

(E) Homemaker and handyman/chore services not directly related to medical need pursuant to Section 63.04(E) and (G);

(F) Those services which can be reasonably obtained by the consumer by going outside his/her place of residence;

(G) Supervisory visits made for the purpose of supervising home health aides, certified nursing assistants, or personal care assistants; and

(H) Custodial or supervisory care.

63.06 POLICIES AND PROCEDURES

(A) Eligibility Determination

An eligibility assessment, using the Department's approved MED assessment form, shall be conducted by the Department or the Assessing Services Agency. All other Home Based Care services require eligibility determination and prior authorization by the Assessing Services Agency to determine eligibility pursuant to Section 63.02.

(1) The Assessing Services Agency will accept verbal or written referral information on each prospective new consumer, to determine appropriateness for an assessment. When funds are available to conduct assessments, appropriate consumers will receive a face to face medical eligibility determination assessment at their current residence within the time requirement specified by BEAS in the contract, of the date of referral to the Assessing Services Agency. All requests for assessments shall be documented indicating the date and time the assessment was requested and all required information provided to complete the request. The individual conducting the assessment shall be a Registered Nurse (RN) and will be trained in conducting assessments and developing an authorized plan of care with the Department's approved MED form. The assessor shall, as appropriate within the exercise of professional judgment, consider documentation, perform observations and conduct interviews with the long-term care consumer, family members, direct care staff, the consumer's physicians and other individuals and document in the record of the assessment all information considered relevant in his or her professional judgment. The RN assessor's findings and scores recorded in the MED form shall be the basis for establishing eligibility for services and the authorized plan of care. The anticipated costs of covered services

to be provided under the authorized plan of care must conform to the limits set forth in Section 63.03(A-E) and 63.04.

(2) The Assessing Services Agency shall inform the consumer of available community resources and authorize a plan of care that reflects the identified needs documented by scores and timeframes on the MED form, giving consideration to the consumer's living arrangement, informal supports, and services provided by other public and private funding sources. HBC services provided to two or more consumers sharing living arrangements shall be authorized by the Assessing Services Agency with consideration to the economies of scale provided by the group living situation, according to limits in Section 63.03 and 63.04. The Assessing Services Agency shall assign the appropriate level of care for which the consumer is eligible (see Section 63.02) and authorize a plan of care based upon the scores and findings recorded in the MED assessment. The covered services to be provided in accordance with Level I, II, III or IV and the authorized plan of care shall: 1) not exceed the lesser of the monthly plan of care authorized by the Assessing Services Agency or the financial caps established by the Bureau of Elder and Adult Services for the corresponding level of care; 2) be prior authorized by the Department or its Assessing Services Agency. The assessor shall approve an eligibility period for the consumer, based upon the scores and needs identified in the MED assessment and the assessor's clinical judgment. An initial eligibility period shall not exceed three (3) months.

(3) The assessor will provide a copy of the authorized plan of care, in a format understandable by the average reader, a copy of the applicable eligibility notice, release of information and the appeal hearing rights notice, to the consumer at the completion of the assessment. The assessor will inform the consumer of the estimated co-payment and the cost of services authorized.

(4) The assessor shall forward the completed assessment packet to the Department's authorized Home Care Coordinating Agency within seventy-two (72) hours of the medical eligibility determination and authorization of the plan of care.

(5) The Home Care Coordinating Agency shall contact the consumer within the time required under their contract with BEAS of transmission of the MED assessment and authorized plan of care. The Home Care Coordinating Agency shall assist the consumer with locating providers and obtaining access to services authorized on the careplan summary by the Assessing Services Agency or the Department. The Home Care Coordinating Agency shall implement and coordinate services with the provider agency or independent contractor using service orders, as well as, monitor service utilization and assure compliance with this policy.

(6) The provider or independent contractor shall request through the Home Care Coordinating Agency any change in the authorized plan of care. The Home Care Coordinating Agency shall be responsible to assure that the authorized service plan shall not exceed the lesser of the plan of care

authorized by the Assessing Services Agency or the financial cap established by the Department for the level of Home Based Care authorized.

(7) The direct care provider or independent contractor contracted by the Home Care Coordinating Agency to provide skilled nursing services shall develop a nursing plan of care, which shall be reviewed and signed by the recipient's physician. It shall include the personal care and nursing services authorized by the Assessing Services Agency or the Department, and the medical treatment plan signed by the recipient's physician. A copy must be forwarded to the Home Care Coordinating Agency at no additional charge.

(8) The Home Care Coordinating Agency will complete standardized referral requests for reassessment and submit the requests to the Department or the Assessing Services Agency at least five (5) days prior to the reassessment due date. The most up to date status of the consumer as reported by the care coordinator, care monitor and any MDT findings must be included in the reassessment request.

(B) Waiting List

(1) When funds are not available to assess all prospective consumers, the Assessing Services Agency will establish a statewide waiting list for assessments. As funds become available, consumers will be assessed on a first come, first served basis.

(2) For consumers found ineligible for HBC services the Assessing Services Agency will inform each consumer of alternative services or resources, and offer to refer the person to those other services.

(3) When funds are not available to serve new consumers who have been assessed for eligibility or to increase services for current consumers, a waiting list will be established by the Home Care Coordinating Agency. For consumers on the wait list, eligibility will be advisory only. As funds become available consumers will be taken off the list and served on a first come, first served basis~~.~~ and eligibility will be determined and a plan of care authorized.

(4) When there is a waiting list, the Home Care Coordinating Agency will inform each consumer who is placed on the waiting list of alternative services or resources, and offer to refer the person to those other services.

(5) The Home Care Coordinating Agency will maintain one statewide waiting list.

(6) Consumer names may be removed from the waiting list if the HCCA determines that another funding source is available to the consumer, or the consumer has entered a hospital, residential care facility or nursing facility

for longer than 30 days or upon the death of the consumer.

(C) **Suspension** Services may be suspended for up to thirty (30) days. If such circumstances requiring suspension extend beyond thirty (30) days, the consumer's eligibility in the program will be terminated. After services are terminated, a consumer will need to be reassessed to determine medical eligibility for services and be subject to the requirements of the waiting list. If the HCCA does not become aware until after 30 days that the consumer has been hospitalized or is using institutional care services, the consumer will be terminated as of the date the HCCA verifies the change in status.

(D) **Reassessment and Continued Services**

(1) For all recipients under this section, in order for the reimbursement of services to continue uninterrupted beyond the approved classification period, a reassessment and prior authorization of services is required and must be conducted within the timeframe of five (5) days prior to and no later than the reassessment due date. HBC payment ends with the reassessment date, also known as the end date. If the reassessment date for a consumer occurs within the thirty-day suspension period, that reassessment date will be extended for as long as services are suspended, but no later than the last day of the thirty-day suspension period. If services are suspended beyond thirty-days, the consumer's eligibility in the program will be terminated. After services are terminated, a consumer will need to be reassessed to determine medical eligibility for services and will be placed on the waiting list and will be subject to the waiting list requirements.

(2) An individual's specific needs for Home Based Care Services must be reassessed at least every six months;

(3) Unscheduled reassessments due to financial changes that may potentially result in a change in program funding source must be requested by the Home Care Coordinating Agency.

(4) Unscheduled financial reassessments may be completed by the Home Care Coordinating Agency when a spouse or significant other household member passes away or there has been a documented change of 20% or greater in the asset or income level of the household;

(5) Unscheduled reassessments due to eligibility or service needs must be justified with consideration given to any MDT findings and requested by the Home Care Coordinating Agency.

(6) Significant change reassessments will be requested by the Home Care Coordinating Agency according to the definition in Section 63.01(GG). The Assessing Services Agency will review the request and the most recent assessment to determine whether a reassessment is warranted and has the potential to change the level of care or alter the authorized plan of care.

(7) For consumers currently under the appeal process, reassessments will not be conducted unless the consumer experiences a significant change as

defined in Section 63.01(GG) or has an acute or emergency episode as defined in Section 63.01(C).

63.07 Professional and Other Qualified Staff

(A) As Authorized Agents of the Bureau the Assessing Services Agency and the Home Care Coordinating Agency shall:

(1) Employ staff qualified by training and/or experience to perform assigned tasks and meet the applicable licensure requirements.

(2) Comply with requirements of 22 M.R.S.A. §3471 et seq. and 22 M.R.S.A. §4011-4017 to report any suspicion of abuse, neglect or exploitation.

(3) Pursue other sources of reimbursement for services prior to the authorization of HBC services.

(4) Operate and manage the program in accordance with all requirements established by rule or contract.

(5) Have sufficient financial resources, other than Federal or State funds, available to cover any Home Based Care expenditures that are disallowed as part of the Bureau of Elder and Adult Services utilization review process.

(6) Inform in writing any consumer or any designated representative of a consumer with an unresolved complaint regarding their services about how to contact the Long Term Care Ombudsman.

(7) Assure that costs to HBC funds for services provided to a consumer in a twelve month period do not exceed the applicable annual authorized care plan cost limit, per level of care for which the consumer is determined eligible, established by the Bureau of Elder and Adult Services. When HBC is used to supplement state or MaineCare funded assisted housing services, HBC funds can be used only to the extent that the sum of support from the other funding source(s) and HBC does not exceed the applicable HBC annual care plan cost limit, for Level IV of care, established by the Bureau of Elder and Adult Services.

(8) Assure when hiring or contracting for delivery of services that conflict of interest has been disclosed and measures taken to avoid the issue in provision of services. If conflict of interest is identified, document that specific measures have been taken to comply.

(B) The Assessing Services Agency shall:

(1) Implement an internal system to assure the quality and appropriateness of assessments to determine eligibility and authorize care plans including, but not limited to the following:

(a) Consumer satisfaction surveys;

(b) Documentation of all complaints, by any party including resolution action taken;

(c) Measures taken by the Authorized Agent to improve services as identified in (a) and (b).

(2) Consider, as appropriate, any findings of the MDT. The Assessing Services Agency will consider, as appropriate, these findings, when

completing the assessment and reassessment in the development of the authorized plan of care that promotes the consumer's independence.

(3) Forward to the Home Care Coordinating Agency the completed assessment, consumer friendly plan of care, signed choice letter and signed release of information. Maintain individual consumer records that include the above items.

(4) Participate in the Quality Assurance Review Committee as required by Bureau of Elder and Adult Services

C. The Home Care Coordinating Agency shall:

(1) Assure that service providers employed by agencies and independent contractors meet applicable licensure and/or certification and/or training requirements, and maintain records which show entrance and exit times of visits, total hours spent in the home, and tasks completed. Travel time to and from the location of the consumer is excluded.

(2) Maintain annual written agreements with service providers employed by agencies and independent contractors, and communicate current policy or service rate changes to all providers.

(3) Implement an internal system to assure the quality and appropriateness of services delivered including, but not limited to the following:

(a) Consumer satisfaction surveys;

(b) Documentation of all complaints, by any party including resolution action taken;

(c) Measures taken by the Authorized Agent to improve services as identified in (a) and (b).

(4) Include a provision in service provider agreements for reimbursing the Home Care Coordinating Agency if services paid for by HBC are subsequently reimbursed by another payor.

(5) Establish MDT's who will review plans of care, as needed, to identify overlaps of service, over utilization of services or deficits in plans of care. Consider, as appropriate, any findings of the MDT when implementing the authorized plan of care and issuing service authorizations. The RN assessor is considered a member of the MDT

(6) Assure contact with each consumer as required under the contract with BEAS to verify receipt of authorized services, discuss consumer's status, review any unmet needs and provide appropriate follow-up and referral to community resources.

(7) Employ either directly or through contract face-to-face care monitors and care coordinators who are either a licensed social worker or registered professional nurse with at least one year of community service experience.

(8) Assure that all contracts for personal support services and homemaker services require checks of the CNA registry and criminal background for all employees prior to the provision of services by the employees of the agency under contract with the HCCA.

(9) Participate in the QARC meetings as required by Bureau of Elder and Adult Services

(10) Reimburse providers in accordance with these rules and the HCCA contract with the Department based on the unit of service and rates established by the Department

(11) Recoup funds for services provided if the sub-contracted agency or Family Provider did not provide required documentation to support qualifications of the agency, staff or services billed

(12) Ensure the quality of services and has the authority to determine whether a PCA agency or Family Provider has the capacity to comply with all service requirements. Failure to meet standards must result in no-approval or termination of the sub-contract for PCA services. Termination of a sub-contract cannot be appealed under Section 40.

(13) Contract with a Fiscal Intermediary who agrees to perform employer-related tasks and administrative tasks specified in Section 63.01-(R), including but not limited to tasks described in Section 63.07(I).

(D) Registered Professional Nurse

A registered professional nurse employed directly or through a contractual relationship with a home health agency or acting as an individual practitioner may provide services by virtue of possession of a current license to practice their health care discipline in the State in which the services are performed.

(E) Licensed Practical Nurse

A licensed practical nurse employed directly or through a contractual relationship with a home health agency may provide services by virtue of possession of a current license to practice their health care discipline in the State in which the services are performed provided they are supervised by a registered professional nurse.

(F) Home Health Aide

Any home health aide employed by a home health agency must have satisfactorily completed a training program for certified nurse assistants and receive supervision consistent with the rules and regulations of the Maine State Board of Nursing. Home health aides employed by a home health agency must also have satisfactorily completed an agency orientation as defined by the Regulations governing the Licensing and Functioning of Home Health Care Services and be listed on the CNA registry.

(G) Certified Nursing Assistant (CNA)

A CNA employed by, or acting under a contractual relationship with, a home health agency must have satisfactorily completed a training program for certified nurse assistants and receive supervision consistent with the Rules and Regulations of the Maine State Board of Nursing and be listed on the CNA registry.

(H) Certified Nursing Assistant/Medications

A CNA who meets the requirements in Section 63.07(G) above and has satisfactorily completed Department-approved medication course for certified

Nursing Assistants, consistent with Rules and regulations of the Maine State Board of Nursing and be listed on the CNA registry.

(I) Fiscal Intermediary

The FI acts as an agent of the employer in matters related to the employment of personal support specialist and purchase of other support services or goods, including but not limited to carrying out payroll and tax and functions necessary to ensure compliance with federal and state tax and labor laws and program rules.

(J) Social Worker

A social worker must hold a Master's Degree from a school of social work accredited by the Council on Social Work Education, and must be licensed through the Maine Board of Social Worker Registration as documented by written evidence from such Board pursuant to 32 MRSA Chapter 83, and may provide only those services allowed under the scope of that license.

(K) Physical Therapist

A physical therapist must be a graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent and must be licensed by the State of Maine. A physical therapist may be reimbursed for services provided in his or her own office if the therapist is approved by Medicare pursuant to 42 CFR §405.1730.

(L) Occupational Therapist

An occupational therapist must be licensed to practice occupational therapy by the Maine Board of Occupational Therapy Practice, as documented by written evidence from such Board.

(M) Speech Pathologist

A speech pathologist must be licensed to practice speech pathology by the Maine Board of Examiners on Speech Pathology and Audiology, as documented by written evidence from such Board.

63.08 Consumer Records and Program Reports

(A) Content of Consumer Records. The Home Care Coordinating Agency must establish and maintain a record for each consumer that includes at least:

(1) The consumer's name, address, mailing address if different, and telephone number;

(2) The name, address, and telephone number of someone to contact in an emergency;

(3) Complete medical eligibility determination form and financial assessments and reassessments that include the date they were done and the signature of the person who did them;

(4) A care plan summary that promotes the consumer's independence, matches needs identified by the scores and timeframes on the MED form and authorized by the Assessing Services Agency, gives consideration of other formal and informal services provided and which is reviewed no less frequently than semiannually. The service plan includes:
   (a) Evidence of the consumer's participation;
   (b) Identification of needs;
   (c) The desired outcome;
   (d) Who will provide what service, when and how often, reimbursed by what funding source, the reason for the service and when it will begin and end; and
   (e) The signature of the nurse assessor who determined eligibility and authorized a plan of care and the Home Care Coordinating Agency staff who authorized the actual service plan.

(5) A dated release of information signed by the consumer that conforms with applicable state and federal law is renewed annually and that:
   (a) Is in language the consumer can understand;
   (b) Names the agency or person authorized to disclose information;
   (c) Describes the information that may be disclosed;
   (d) Names the person or agency to whom information may be disclosed;
   (e) Describes the purpose for which information may be disclosed; and
   (f) Shows the date the release will expire.

(6) Documentation that consumers eligible to apply for a waiver for consumer payments, were notified that a waiver may be available;

(7) A copy of the consumer's signed and dated request form authorizing the Home Care Coordinating Agency to arrange services described in the authorized plan of care;

(8) Evidence that a PCA, unless employed through a contract with a provider agency, meets the employment requirements described in section 63.10;

(9) Monthly service orders to providers that specify the tasks to be completed;

(10) Written progress notes that summarize any contacts made with or about the consumer and:
   (a) The date the contact was made;
   (b) The name and affiliation of the person(s) contacted or discussed;
   (c) Any changes needed and the reasons for the changes in the plan of care;
   (d) The results of any findings of MDT contacts or meetings and, if applicable, of quality assurance review committee (QARC) meetings; and
   (e) The signature and title of the person making the note and the date the entry was made.

(B) Written Progress Notes for Services Delivered by a Direct Care Provider (includes HCCA sub-contracted agencies)

Written progress notes shall contain:

(1) The service provided, date, and by whom;

(2) Entrance and exit times of nurse's, home health aide's, certified nursing assistant's and personal support specialist's visits and total hours spent in the home for each visit. Exclude travel time [unless provided as a service as described in this Section];

(3) A written service plan that shows specific tasks to be completed and the schedule for completion of those tasks;

(4) Progress toward the achievement of long and short range goals. Include explanation when goals are not achieved as expected;

(5) Signature of the service provider; and

(6) Full account of any unusual condition or unexpected event, dated and documented.

(C) Program Reports. The following reports must be submitted to Bureau of Elder and Adult Services, in a format approved by the Bureau of Elder and Adult Services, by the day noted:

(1) Monthly service and consumer reports including admissions, discharges and active client lists, due no later than twenty days after the end of the month;
(2) Monthly fiscal reports, due no later than twenty days after the end of the month;
(3) Quarterly and annual demographic reports, due no later than twenty five days after the end of the quarter; and
(4) Monthly authorizations for HBC services, due by the fifth of the month for which authorizations are reported.
(5) Monthly reports of the type and number of assessments completed by the Assessing Services Agency as required by the contract with Bureau of Elder and Adult Services.

63.09 RESPONSIBILITIES OF THE BUREAU OF ELDER AND ADULT SERVICES

(A) Selection of Authorized Agent. To select authorized agencies, the Bureau of Elder and Adult Services will request proposals by publishing a notice in Maine's major daily newspapers and posting on the Bureau of Elder and Adult Services website. The notice will summarize the detailed information available in a request for proposals (RFP) packet and will include the name, address, and telephone number of the person from whom a packet and additional information may be obtained. The packet will describe the specifications for the work to be done. Criteria used in selection of the successful bidder or bidders will include but are not necessarily limited to:

(1) Cost;

(2) Organizational capability;
(3) Response to a sample case study;
(4) Qualifications of staff;
(5) References;
(6) Quality assurance plan;
(7) Ability to comply with applicable program policies; and
(8) Demonstrated experience.

(B) Other Responsibilities of the Bureau of Elder and Adult Services. The Bureau of Elder and Adult Services is responsible for:

(1) Setting the annual individual care plan cost limit for each level of care.
(2) Establishing performance standards for contracts with authorized agencies including but not limited to the numbers of consumers to be assessed and served and allowable costs for administration and direct service.
(3) Conducting or arranging for quality assurance reviews that will include record reviews and home visits with HBC consumers.
(4) Establishing and maintaining regional quality assurance review committees (QARCs).
    (a) The QARC is responsible for:
        (i) Making recommendations for policy changes to the Bureau of Elder and Adult Services;
        (ii) Reviewing randomly selected cases and make recommendations for improving quality of care and outcomes for the consumer. The QARC may review additional cases chosen by the staff;
        (iii) Meeting as often as necessary, but at least ~~four~~ twice ~~times~~ annually; and
        (iv) Using procedures that insure consumer confidentiality.
    (b) The QARC shall have at least six (6) members, and must elect a chairperson who is not an employee of the Assessing Services Agency, Home Care Coordinating Services or State Agency. Bureau of Elder and Adult Services is responsible for scheduling, notifying and recruiting new members, documenting and distributing the meeting minutes and case review summaries to all members. Membership on the QARC must include:
        (i) The Home Care Coordinating Agency staff;
        (ii) The Assessing Services Agency staff;
        (iii) Service providers;
        (iv) Consumers or consumer caregivers;
        (v) Agencies/organizations that have an interest in elderly or other adults; and
        (vi) Bureau of Elder and Adult Services staff.

(5) Providing training and technical assistance.
(6) Providing written notification to the administering agencies regarding strengths, problems, violations, deficiencies or disallowed costs in the program and requiring action plans for corrections.

(7) Assuring the continuation of services if the Bureau of Elder and Adult Services determines that an Authorized Agent's contract must be terminated.

(8) Administering the program directly in the absence of a suitable Authorized Agent.

(9) Conducting a request for proposals for authorized agents at least every five years thereafter.

(10) At least annually, review randomly selected requests for waivers of consumer payment.

(11) Recouping HBC funds from administering agencies when Bureau of Elder and Adult Services determines that funds have been used in a manner inconsistent with these rules or the Authorized Agent's contract.

63. 10 PERSONAL SUPPORT SERVICES

(A) Scope. This section applies to personal support services provided to consumers of the In-Home and Community Support Services for Elderly and other Adults program by a person who has furnished evidence of competence to carry out the assigned tasks by virtue of previous experience or training. Personal Support Specialist (PSS) is an individual defined in Section 63.01 (FF) who delivers services as defined in Section 63.04(F) of this manual and who meets the training or competency requirements described in this Section. A PSS may provide assistance with ADLs and IADLs when they meet the requirements of this Section.

(B) Use of PSS Services.

(1) A PSS may be used when the ADL needs of the consumer can be met with this level of service provider;

(2) Family and household members providing PSS services and seeking payment by the program must comply with the training and competency requirements of this section unless exempted under this section;

(3) The PSS shall perform tasks that are consistent with the Assessing Services Agency authorized plan of care and the Home Care Coordinating Agency service authorization;

(4) With the exception of Family Providers who are consumers managing their own care, PSS employed by agencies must receive on-site supervision by their employer as described in Section 63.10(E)(5);

(5) The consumer and/or family has the right to request a change in personal support specialist. If it is not possible for the consumer and the agency together to resolve the issues that have caused the consumer to request a change, the agency will make the change, if alternate staff are available.

(C) **Family Provider Service Option** is a service provision option that allows an adult, twenty–one years or older, to register as a Personal Care Attendant Agency solely for the purpose of managing his or her own services or solely for managing

the services of no more than two of his/her family members. For purposes of this definition only, family members include individuals related by blood, marriage or adoption as well as two unmarried adults who are domiciled together under a long-term arrangement that evidences a commitment to remain responsible indefinitely for each other's welfare. Unless specifically exempted in this subsection or elsewhere in Section 63, all other requirements of Section 63 apply to the Family Provider Service option.

Consumers who are currently participating in the self-directed option, previously described in Section 63.05, must transition immediately, but no later than 45 days from the effective date of these rules to the Family Provider Option, or HCCA managed Home Based care services.

(1) The following requirements apply to the Family Provide Service Option:

(b) The consumer or family member must register as a personal care agency (the "Family Provider") with the Department of Health and Human Services pursuant to Title 22 MRSA 1717.

(c) The Family Provider must conduct a criminal history background check for any individual hired as a personal support specialist; and not employ an individual who is prohibited from employment under Title 22 MRSA 1717(3);

(d) The adult who is registered as the agency may not be paid to provide care to the consumer;

(e) A consumer's guardian may not be paid to provide care to the consumer;

(f) Family Provider must use a Fiscal Intermediary as a payroll agent approved by the HCCA; and

(g) Failure by the Family Provider to comply with the HCCA contract requirements shall result in a termination of the contract with the HCCA.

(2) As part of the Family Provider Services Option, the Home Care Coordinating Agency (HCCA) shall:

(a) check the CNA Registry and conduct a criminal background check on the individual who registers as a personal care agency
(b) establish a monthly cost limit based on the authorized plan of care;
(c) manage professional and/or covered services (RN, ERS for example), other than personal support services; if requested by the consumer or family provider,
(d) contract with a Fiscal Intermediary (FI); and
(e) recoup funds for services delivered in non-compliance with this section.

(D) Training and Competency. To be reimbursed, PSSs must meet the requirements of this subsection. To meet training requirements, a PSS must:

(1) Currently be listed on the Certified Nursing Assistant's registry.

(a) CNAs who lapse their registry status due to a non-completion of the required employment in a health care institution, may choose to take the competency-based examination of didactic and demonstrated skills from BEAS approved curriculum. Successful passing of this examination will result in a certificate of training as a Personal Support Specialist.

(b) If the competency-based examination is not completed successfully the CNA must complete the training requirements outline in Section C (3); or

(2) Provide evidence of satisfactory completion of a basic nurse's aide or home health aide training program meeting the standards of the Maine State Board of Nursing within the past three (3) years.

(a) The applicants may choose to take the competency-based examination of didactic and demonstrated skills from ~~any~~ BEAS approved curriculum. Successful passing of this examination will result in a certificate of training as a Personal Support Specialist.

(b) Applicants who have completed a basic nurse's aide course or home health aide training program outside the past three years may choose to take the competency-based examination of didactic and demonstrated skills from any BEAS approved curriculum. Successful passing of this examination will result in a certificate of training as a Personal Support Specialist.

(c) If the competency-based examination is not completed successfully, the applicant must complete the training requirements outlined in Section C (3)or;

(3) Provide evidence of satisfactory completion of a Department approved training course. The training shall meet the following conditions:

(a) The course must include at least 50 hours of formal classroom instruction, demonstration, return demonstration, and examination and must cover the tasks included in Section 63.01(CC); and

(b) Provide evidence of successful passing of a competency-based examination of didactic and demonstrated skills resulting in a certificate of training as a Personal Support Specialist.

(4) PSSs must complete the training and examination within six (6) months of employment.

(a) With the exception of Family Providers, a newly hired PSS who does not yet meet the Department's training and examination requirements must undergo an eight (8) hour orientation by the employing agency that reviews the role and responsibilities of a PSS. A Family Provider must provide adequate orientation to meet the needs of the consumer(s) and document provision of the orientation in the consumer's record.

(b) The orientation must be completed before the PSS starts delivering services to consumers.

(c) The PSS must demonstrate competency in all required tasks prior to being assigned to a consumer's home. Demonstration of competency must be documented in the employee's record and include the scope of the demonstration and the signature of the individual certifying competency.

(d) PSSs newly hired to an agency, who meet the Department's training and/or certification requirements, must receive an agency orientation. The training and certification document must be on file in the individual's personnel record.

(e) When the nature of the tasks or the condition of the consumer warrant the specialized knowledge and skills of a health professional, as determined by the medical eligibility assessment, the PSS shall be trained by the health professional and satisfactorily demonstrate the skill to carry out the necessary tasks.

(5) Exemptions

(a) The Department may waive training requirements for personal support specialists under the Family Provider Option if that individual worked for the consumer under the MaineCare Attendant Services Benefit, the Physically Disabled Home and Community Benefits or Consumer Directed Home Based Care program, self-directed option under Section 63, prior to July 1, 2004**.**

(b) Personal Support Specialists (PSSs)who received and successfully completed a BEAS approved curriculum prior to 9/1/03, will be grandfathered and allowed to continue to provide home care services as a Personal Support Specialist (PSS).

(E) Employment or Provider Agency Responsibilities.

(1) Providers employing Personal Support Specialists (PSSs) must assure that all PSSs meet the applicable training and competency requirements in 63.10(C). The responsibility for verification of PSS credentials rests with the employer.

(a) family and household members who are reimbursed for PSS services must comply with the training and competency rules

(b) evidence of the orientation, the certificate of training, and/or verification of competency, a criminal background check and CNA registry check shall be maintained in the PSS personnel file.

(2) Providers employing PSSs, CNA, Home Health Aides or homemakers working as Personal Support Specialist must check the CNA Registry and complete a criminal background check and may not employ an individual as a personal support specialist who is prohibited from employment under Title 22 MRSA 1717(3).

(3) Providers must develop and implement personnel policies which insure a smoke free environment. PSSs are not allowed to smoke, use alcohol or controlled substances in the consumer's home or vehicle during work hours.

(4) With the exception of Family Service Providers who are consumers managing their own care, a visit shall be made in a consumer's home by a supervisor or Agency representative prior to the start of PSS services to develop and review with the consumer the plan of care as authorized by the Assessing Services Agency on the care plan summary and by the Home Care Coordinating Agency on the service order.

(5) Supervisory visits: With the exception of Family Service Providers who are consumers managing their own care, for Level III and IV PSSs employed by agencies must receive on-site supervision of the implementation of the Level III and Level IV consumer's authorized plan of care by their employer at least quarterly to verify consumer satisfaction with the PSS performance in meeting the care plan tasks. For Level I and Level II consumers, on-site supervision must be at least once every six months with quarterly phone calls to the consumer. Direct on site supervision of the PSS, outside of the plan of care implementation and consumer satisfaction mentioned above, is up to the discretion of the provider agency and their personnel policies and procedures.

(6) PSS agencies operated by consumers or family members must agree to on-site home supervisory visits by the HCCA to evaluate the condition of the consumer, implementation of the care plan, and whether the services are satisfactory to the consumer and the HCCA. Failure to allow the HCCA on-site visits is grounds for terminating reimbursement to the PCA PSS worker or the PSS-worker or terminating the contract with the agency.

(7) Each Personal Support Specialist's personnel record must include:

(a) which of the criteria in section 63.10(C) were met for certifying the PSS.

(b) documentation of the demonstration of competency that includes the scope of the demonstration and the signature of the individual certifying competency on Department approved forms.

(c) If the PSS has not completed the training program for services under the Family Provider Service Option, the record must indicate the reason for exemption.

(8) Maintenance of consumer records:

(a) A written service plan that shows specific tasks to be completed and schedule for completion of those tasks;

(b) Documentation which shows the entrance and exit times of PSS visits and total time spent in the home;

(c) The name and telephone number of the person to call in case of an emergency or other needed information.

63.11 Consumer Payments

(A) Consumer Payments. The administering agency will use a Bureau of Elder and Adult Services approved form to determine the client's income and liquid assets and calculate the monthly payment to be made by the consumer. The agency may require the consumer and his or her spouse to produce documentation of income and liquid assets. A consumer need not complete a financial assessment if he or she pays the full cost of services received. His or her payments, as determined by an annual financial assessment may not exceed the total cost of services provided.

(B) Definitions. The following definitions apply to this Section.

(1) Dependent allowances. Dependents and dependent allowances are defined and determined in agreement with the method used in MaineCare. The allowances are changed periodically and cited in the MaineCare Benefits Manual, TANF Standard of Need Chart. Dependents are defined as individuals who may be claimed for tax purposes under the Internal Revenue Code and may include a minor or dependent child, dependent parents, or dependent siblings of the consumer or consumer's spouse. A spouse may not be included.

(2) Disability-related expenses: Disability-related expenses are out-of-pocket costs incurred by the consumers for their disability, which are not reimbursed by any third-party sources. They include:

(a) Home access modifications: ramps, tub/shower modifications and accessories, power door openers, shower seat/chair, grab bars, door widening, environmental controls;

(b) Communication devices: adaptations to computers, speaker telephone, TTY, Personal Emergency Response Systems;

(c) Wheelchair (manual or power) accessories: lap tray, seats and back supports;

(d) Vehicle adaptations: adapted carrier and loading devices, one communication device for emergencies (limited to purchase and installation), adapted equipment for driving;

(e) Hearing Aids, glasses, adapted visual aids;

(f) Assistive animals (purchase only);

(g) Physician ordered medical services and supplies;

(h) Physician-ordered prescription and over the counter drugs; and

(i) Medical insurance premiums, co-pays and deductibles.

(3) **Household members:** means the consumer and spouse.

(4) **Household members' income includes:**

(a) Wages from work, excluding state and Federal taxes and employer mandated or court ordered withholdings;

(b) Benefits from Social Security, Supplemental Security Income, pensions, insurance, independent retirement plans, annuities, and Aid and Attendance;

(c) Adjusted gross income from property and/or business, based on the consumer's most recent Federal income tax;

(d) Interest and dividends.

(e) Regularly occurring payments received from a home equity conversion mortgage.

Not included are benefits from: the Home Energy Assistance Program, Food Stamps, General Assistance, Property Tax and Rent Refund, emergency assistance programs, or their successors.

(5) A **liquid asset** is something of value available to the consumer that can be converted to cash in three months or less and includes:

(a) Bank accounts;

(b) Certificates of deposit;

(c) Money market and mutual funds;

(d) Life insurance policies;

(e) Stocks and bonds;

(f) Lump sum payments and inheritances; and

(g) Funds from a home equity conversion mortgage that are in the consumer's possession whether they are cash or have been converted to another form.

Funds which are available to the consumer but which carry a penalty for

early withdrawal will be counted minus the penalty. Exempt from this category are mortuary trusts and lump sum payments received from insurance settlements or annuities or other such assets named specifically to provide income as a replacement for earned income. The income from these payments will be counted as income.

(C) Consumer Payment Formula. The provider agency will use the following formula to determine the amount of each consumer's payment.

Step (1) - Calculate the Monthly Contribution from Income.

(a) Total the monthly income of the consumer and spouse.

(b) Deduct monthly allowable disability related expenses.

(c) Deduct monthly allowable dependent allowances.

(d) Multiply the net income by 4%.

Step (2) - Calculate the Monthly Contribution from Liquid Assets.

(a) Total the liquid assets of the household members.

(b) Deduct annual interest and annual dividends counted towards income for the household.

(c) Subtract $15,000 from the amount of liquid assets calculated in Step (2)(a&b). If the result is less than zero use zero.

(d) Multiply the sum calculated in Step (2)(c) by 3%. The result is the Monthly Contribution from Liquid Assets

Step (3) - Add the result of the calculation in Step (1)(d) to the result of the calculation in Step (2)(d).

Step (4) - The consumer's monthly payment is the lesser of the sum calculated in Step (3) or the actual cost of services provided during the month.

Step (5) - When two persons in a household are both receiving Home Based Care services under this program, collect the required information for each person. Calculate the co-pay for each consumer and combine the total. Divide the amount by two to determine the household monthly co-payment.

(D) Waiver of Consumer Payment. Consumers will be informed that they may apply for a waiver of all or part of the assessed payment when:

(1) Monthly income of household members is no more than 200% of the federal poverty level; and

(2) Household assets are no more than $15,000.

63.12 Method for Reviewing Requests for Waivers of Consumer Payment

(A) Consumers requesting waivers may be asked to provide verification of any income, liquid assets and expenses for housing, transportation, unreimbursed medical expenses, food, clothing, laundry and insurance.

(B) Consumers may request a waiver from the Home Care Coordinating Agency of all or part of the assessed payment.

(1) The request must be submitted in writing:

(a) within ten (10) days of the date of notification of the assessed consumer payment, or

(b) within ten (10) days of the date of their last functional reassessment, or

(c) within ten (10) days of the date the consumer began to receive services after being on the waiting list.

(2) Requests for waiver must be on a form approved by the Bureau of Elder and Adult Services.

(3) The administering agency will act on the request and inform the consumer of its decision in writing within twenty (20) days of receipt of the request.

(4) If the administering agency needs additional information, in order to determine whether the waiver can be granted, the administering agency will promptly notify the consumer. The consumer must submit the additional information within ten (10) days. In such cases the agency will issue its decision within ten (10) days of receipt of the additional information.

(C) A consumer who is otherwise eligible may receive services while awaiting the agency's decision on the request for waiver. The agency will hold the consumer payment in abeyance pending a decision on the request, or the completion of the appeals process, whichever is later

(D) The agency will inform the consumer in writing if the request for a waiver is approved or denied. If denied, the agency's notice must include information on appeal rights.

(E) If the waiver is denied, the consumer payment, including payments held in abeyance, is due within thirty (30) days of the date of the decision, or services will be terminated.

(F) When allowable expenses plus the consumer payment exceed the sum of monthly income plus the Monthly Contribution From Liquid Assets, the agency will waive the portion of the payment that causes expenses to exceed income.

(G) Consumers who have applied for a full or partial waiver of the assessed payment and been denied may reapply only if one of the following conditions exists and is expected to continue until the next regularly scheduled financial assessment:

(1) the consumer has at least a 20% decrease in monthly income or liquid assets.

(2) the consumer has an increase in expenses which results in the sum of the allowable expenses plus the consumer payment exceeding monthly income plus the Monthly Contribution From Liquid Assets.

(H) Expenses. Expenses will be reduced by the value of any benefit received from any source that pays some or all of the expense. Examples include but are not limited to, Medicare, MaineCare, Food Stamps and Property Tax and Rent Refund. Business expenses that exceed business income are not allowable. Allowable expenses include actual monthly costs of all household members for:

(1) housing expenses which include and are limited to` rent, mortgage payments, property taxes, home insurance, heating, water and sewer, snow and trash removal, lawn mowing, utilities and necessary repairs;

(2) food, clothing and laundry not to exceed;

Monthly Allowance for Food, Clothing and Laundry

Number in Household	1	2	3	4	5 & up
Amount	$217	$343	$459	$577	$694

(3) transportation expenses which include and are limited to ferry or boat fees, car payments, car insurance, gas, repairs, bus, car and taxi fare;

(4) unreimbursed medical expenses including but not necessarily limited to health insurance; prescription or physician ordered drugs, equipment and supplies; and doctor, dentist and hospital bills;

(5) life insurance;

(6) limited discretionary expenses;

The following chart shows maximum allowable discretionary expenses by household size. Amounts in excess of the monthly allowance may not be claimed.

Maximum Allowable Discretionary Expenses

Number in Household	1	2	3	4	5 & up
Amount	$76	$120	$161	$203	$244

APPENDIX to Sec 63 TASK TIME ALLOWANCES - Activities of Daily Living

Activity	Definitions	Time Estimates	Considerations
Bed Mobility	How person moves to and from lying position, turns side to side and positions body while in bed.	5 – 10 minutes	Positioning supports, cognition, pain, disability level.
Transfer	How person moves between surfaces – to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet).	5 – 10 minutes **up to 15 minutes**	Use of slide board, gait belt, swivel aid, supervision needed, positioning after transfer,cognition **Mechanical Lift transfer**
Locomotion	How person moves between locations in his/her room and other areas on same floor. If in wheelchair, self-sufficiency once in chair.	5 - 15 minutes (Document time and number of times done during POC)	Disability level, Type of aids used or Pain
Dressing & Undressing	How person puts on, fastens and takes off all items of street clothing, including donning/removing prosthesis.	20 - 45 minutes	Supervision, disability, pain, cognition, type of clothing, type of prosthesis.
Eating	How person eats and drinks (regardless of skill)	5 minutes	Set up, cut food and place utensils.
		30 minutes	Individual is fed.
		30 minutes	Supervision of activity due to swallowing, chewing,
Toilet Use	How person uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter and adjusts clothes.	5 -15 minutes/use	Bowel, bladder program Ostomy regimen Catheter regimen cognition
Personal Hygiene	How person maintains personal hygiene. (EXCLUDE baths and showers)	Washing face, hands, perineum, combing hair, shaving and brushing teeth — 20 min/day	Disability level, pain, cognition, adaptive equipment.
		Shampoo (only if done separately) — 15 min up to 3 times/ week	
		Nail Care — 20 min/week	
Walking	a. How person walks for exercise only b. How person walks around own room c. How person walks within home d. How person walks outside	Document time and number of times in POC, and level of assist is needed.	Disability Cognition Pain Mode of ambulation (cane) Prosthesis needed for walking
Bathing	How person takes full-body bath/shower, sponge bath (EXCLUDE washing of back, hair), and transfers in/out of tub/shower	15 - 30 minutes	If shower used and shampoo done then consider as part of activity,cognition.